

Check here if this is a revised or an amended invoice / ☐

**COMPREHENSIVE DRUG COURT IMPLEMENTATION
DEPENDENCY DRUG COURT QUARTERLY CLAIM FOR REIMBURSEMENT**

Mail Completed Form To:Department of Alcohol and Drug
Programs**Office of Drug Court Programs**1700 K Street, 5th Floor
Sacramento, CA 95814-4022

County: _____ Grant Award # _____

Grantee: _____
(County Agency identified as Grantee on the Notice of Grant Award)

Address: _____

City/Zip: _____

Phone: _____

Email Address: _____

Project Budget Period From: ____/____/____ To: ____/____/____

Billing Period From: ____/____/____ To: ____/____/____

Summary of Expended Treatment Related Costs (Do not include court related/other costs)

Section I:	A	B	C	D
BUDGET LINE ITEMS	Beginning Balance	Budget Line Item Change (Justification Required)	Current Expense	Ending Balance
Personnel	\$ -	\$ -	\$ -	\$ -
Fringe Benefits	\$ -	\$ -	\$ -	\$ -
Other Administration Costs	\$ -	\$ -	\$ -	\$ -
Travel	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -
Contractual Services	\$ -	\$ -	\$ -	\$ -
Indirect Costs	\$ -	\$ -	\$ -	\$ -
Total of Treatment Related Costs	\$ -	\$ -	\$ -	\$ -

Summary of Expended Court Related/Other Costs (Do not include treatment related costs)

Section II	A	B	C	D
BUDGET LINE ITEMS	Beginning Balance	Budget Line Item Change (Justification Required)	Current Expense	Ending Balance
Personnel	\$ -	\$ -	\$ -	\$ -
Fringe Benefits	\$ -	\$ -	\$ -	\$ -
Other Administration Costs	\$ -	\$ -	\$ -	\$ -
Travel	\$ -	\$ -	\$ -	\$ -
Training	\$ -	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -	\$ -
Contractual Services	\$ -	\$ -	\$ -	\$ -
Indirect Costs	\$ -	\$ -	\$ -	\$ -
Total of Court Related/Other costs	\$ -	\$ -	\$ -	\$ -
GRAND TOTAL (Includes Treatment and Court/Other Costs)	\$ -	\$ -	\$ -	\$ -

I hereby certify that all costs are consistent with the grant award.

X _____ Date: ____/____/____

Alcohol and Drug Program Administrator (AOD)

Please print name of AOD

Please use blue ink for original signature.

Department of Alcohol and Drug Programs Office of Drug Court Programs Use Only

I hereby certify that the required reports for the above billing period have been received.

The fiscal data contained in this invoice has been recorded and submitted to ADP's Accounting

_____ Date: ____/____/____

Comprehensive Drug Court Implementation Project Coordinator

Please print name of Coordinator

ADP Accounting Section Use Only

TC Number:

FY:

Index Code:

PCA Number:

Vendor Number:

Grant:

Forms/Instructions on www.adp.cagov/drugcourthelp.shtml or call (916) 445-9655 for assistance

C:\Documents and Settings\kklemencic\My Documents\in\DDC_CDCL_GRANT_Invoice